

Midfoot Surgery Assessment Form

(Pages 1 & 2 to be completed by surgeon. Pages 3-4 & SF36 to be completed by patient. Surgeon to calculate AOS score).

Name: _____	DOB: ____	Date of Assessment:
Sex: _____		
<i>Patient Label</i>		

Height: _____ cms Weight: _____ Kg Smoker: YES NO

Operation Side: Left Right

Proposed Operation: _____

Pre-operative diagnosis:

<input type="checkbox"/> Lisfranc OA <input type="checkbox"/> Primary OA <input type="checkbox"/> Post-traumatic OA	<input type="checkbox"/> Cuneiform/cuboid/navicular # <input type="checkbox"/> Date of injury <input type="checkbox"/> Previous surgery (specify & date)
<input type="checkbox"/> Lisfranc dislocation <input type="checkbox"/> Date of injury <input type="checkbox"/> TMT # present <input type="checkbox"/> Previous surgery (specify & date)	<input type="checkbox"/> PTTD <input type="checkbox"/> Grade I <input type="checkbox"/> Grade II <input type="checkbox"/> Grade III <input type="checkbox"/> Previous use of orthoses (months)

Previous Operations on Foot:

- Forefoot (specify)
- Midfoot (specify)
- Hindfoot/Ankle (specify)

Other Joints involved:

- | | | |
|---|------|-------|
| <input type="checkbox"/> Subtalar arthrosis | Left | Right |
| <input type="checkbox"/> Subtalar arthrodesis | Left | Right |
| <input type="checkbox"/> Triple fusion | Left | Right |
| <input type="checkbox"/> Midfoot fusion | Left | Right |
| <input type="checkbox"/> Hip arthrodesis | Left | Right |
| <input type="checkbox"/> Knee arthrodesis | Left | Right |
| <input type="checkbox"/> Ankle arthrodesis | Left | Right |

Past Medical History:

<input type="checkbox"/> Steroid treatment <input type="checkbox"/> Immune suppression <input type="checkbox"/> Diabetes <input type="checkbox"/> DVT	<input type="checkbox"/> Ischaemic Heart Disease / Peripheral <input type="checkbox"/> Vascular Disease <input type="checkbox"/> COPD <input type="checkbox"/> Other
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OBJECTIVE ASSESSMENT FOR COMPLETION BY SURGEON

Gait abnormality

- None, slight
- Obvious
- Marked

ROM

- | | |
|--|--|
| <input type="checkbox"/> Extension $\geq 10^\circ$ | <input type="checkbox"/> Flexion $\geq 30^\circ$ |
| <input type="checkbox"/> Extension 5-9° | <input type="checkbox"/> Flexion 15-29° |
| <input type="checkbox"/> Extension $< 5^\circ$ | <input type="checkbox"/> Flexion $< 15^\circ$ |

Hindfoot motion (inversion plus eversion)

- Normal or mild restriction (75%-100% normal)
- Moderate restriction (25%-74% normal)
- Marked restriction (less than 25% normal)

Alignment

- Good, plantigrade foot, midfoot well aligned
- Fair, plantigrade foot, some degree of midfoot malalignment observed, no symptoms
- Poor, nonplantigrade foot, severe malalignment, symptoms

Function

- | | | | |
|----------------------------------|---------------------------------|----------------------------------|---------------------------------|
| PTTD | | | |
| Able to perform single heel rise | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| PT tendon/transfer function | <input type="checkbox"/> Normal | <input type="checkbox"/> Reduced | <input type="checkbox"/> Absent |

SUBJECTIVE ASSESSMENT FOR COMPLETION BY PATIENT

Please tick one square in each of the boxes below that best describes the pain and function relating to your foot.

Pain (If you have no pain in your foot tick “None” and proceed to the Function section.)

None

or:

- Mild, occasional
- Moderate, daily
- Severe, almost always present

- Pain only on starting-up
- Pain only when walking on uneven surfaces
- Pain occasionally when walking on any surface
- Pain always when walking
- Pain at rest or spontaneously

Function

Activity limitations and support requirement (eg walking stick)

- No limitations, no support
- No limitation of daily activities, limited recreational activities, no support
- Limited daily and recreational activities, cane
- Severe limitation of daily and recreational activities, walker, crutches, wheelchair, brace

Maximum walking distance, blocks (1 block~150 metres)

- Greater than 6
- 4-6
- 1-3
- Less than 1

Walking surfaces

- No difficulty on any surface
- Some difficulty on uneven terrain, stairs, inclines, ladders
- Severe difficulty on uneven terrain, stairs, inclines, ladders

Footwear requirements

- Fashionable, conventional shoes, no insert required
- Comfort footwear, shoe insert
- Modified shoes or brace

AOS SCORE

PAIN

The line next to each item represents the amount of pain you typically had in each situation. On the far left is “No pain” and on the far right is “Worst pain imaginable”. Place a mark on the line to indicate how bad your **midfoot pain** was in each of the following situations during the **past week**. If you were not involved in one or more of these situations, place an “X” in the column under the heading “N/A”.

How severe was your midfoot pain:

	No pain		Worst pain imaginable	N/A
1 At its worst?	No pain	_____	Worst pain imaginable	
2 Before you get up in the morning?	No pain	_____	Worst pain imaginable	
3 When you walked barefoot?	No pain	_____	Worst pain imaginable	
4 When you stood barefoot?	No pain	_____	Worst pain imaginable	
5 When you walked wearing shoes?	No pain	_____	Worst pain imaginable	
6 When you stood wearing shoes?	No pain	_____	Worst pain imaginable	
7 When you walked wearing shoe inserts or braces?	No pain	_____	Worst pain imaginable	
8 When you stood wearing shoe inserts or braces?	No pain	_____	Worst pain imaginable	
9 At the end of the day?	No pain	_____	Worst pain imaginable	

To be completed by Surgeon _____/_____ = _____%

DISABILITY

The line next to each item represents the amount of difficulty you had in performing an activity. On the far left is “No difficulty” and on the far right is “So difficult unable”. Place a mark on the line to indicate how much difficulty you had performing each activity because of your **midfoot** during the **past week**. If you did not perform an activity during the past week, place an “X” in the column under the heading “N/A”.

How much difficulty did you have:

	No difficulty		So difficult unable	N/A
1 Walking around the house?	No difficulty	_____	So difficult unable	
2 Walking outside on uneven ground?	No difficulty	_____	So difficult unable	
3 Walking four or more blocks?	No difficulty	_____	So difficult unable	
4 Climbing stairs?	No difficulty	_____	So difficult unable	
5 Descending stairs?	No difficulty	_____	So difficult unable	
6 Standing on tip toes?	No difficulty	_____	So difficult unable	
7 Getting out of a chair?	No difficulty	_____	So difficult unable	
8 Climbing up or down curbs?	No difficulty	_____	So difficult unable	
9 Walking fast or running?	No difficulty	_____	So difficult unable	

To be completed by Surgeon _____/_____ = _____%